

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following are necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND											
10690 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10668											
1. PLACE OF DEATH a. COUNTY St. Mary's Mechanicsville MECHANICSVILLE Rural b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Howard Middle W. Last Anderson					4. DATE OF DEATH Month Sept. Day 13, Year 19 60						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 28, 1916		9. AGE (In years last birthday) 44 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales man					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Magnolia, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Homer B. Anderson					14. MOTHER'S MAIDEN NAME Lula R. Catlin					Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes WWLL					16. SOCIAL SECURITY NO. 221-09-9014		17. INFORMANT Martha B. Anderson Mechanicsville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding Esophageal Varrix 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Portal Cerrhosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Esoph Tongue								INTERVAL BETWEEN ONSET AND DEATH Immed. 5 yrs.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>W.D. Boyd</i> EXAMINER'S NAME (Type) William D. Boyd, M. D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					DATE SIGNED 9/13/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/15/60		22c. NAME OF CEMETERY OR CREMATORY Odd Fellows			22d. LOCATION (City, town, or country) (State) Camden, Delaware				
23. FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Maryland					24a. REC'D BY REGISTRAR SEP 16 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>				

W. Clarke, Lecturer, Georgetown, Maryland

Serial 94560 Odd Fellows

William D. Boyd, I. D.

Delaware

London

94560

X

☐

X

X

Carcinoma of Knox Tongue

5 yrs.

Portal Cirrhosis

Bleeding Esophageal Varix

Armed

Yes

Wali

221-09-9074 1 or the B. Anderson

Homer B. Anderson

Lula R. Catlin

Sales man

Maryland, Delaware

7.3.4.

Male

White

March 28, 1918

44

Anderson

W.

Howard

Sept.

13

60

Funeral Mechanicsville

MECHANICALSVILLE

Mechanicsville

St. Mary's

Maryland

St. Mary's

10684

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY St. Marys MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn				c. LENGTH OF STAY IN 1b X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Harris Last Carter				4. DATE OF DEATH Month September Day 25 Year 19 60			
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1960		9. AGE (In years lost birthday) yrs. 4	IF UNDER 1 YEAR Months 4 Days Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter H. Nelson				14. MOTHER'S MAIDEN NAME Annie M. Carter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Annie M. Carter - Avenue, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.0 with infectious diarrhea DUE TO (b) with dehydration and DUE TO (c) electrolyte imbalance Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/24 , 19 60 , to 9/25 , 19 60 , that I last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville, Md. DATE SIGNED 9/26/60							
ACTUAL SIGNATURE J. Roy Guyther			M.D. Mechanicsville, Md.				
PHYSICIAN'S NAME (Type) J. Roy Guyther, MD			M.D. Mechanicsville, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/60		22c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery		22d. LOCATION (City, town, or county) (State) Morganza, Md	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE OCT 3 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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40-X182XV7

VS. A15MB
SM 7/59

Arthur L. Kraus

W. Clarke Hastings Leonardtown, Md.

Burial 9/23/60 St. Francis Xavier Compagny, Md.

William I. Boyd M. D.

X. C. State St. 335 Lexington Park, Md.

Broken Neck

Margaret Curtis Lexington Park, Md.

Margaret Milburn

Maryland

U.S.A.

Joseph Clarence Curtis

Gas Station Attendant

Male Colored

April 8, 1912

Curtis

September 11, 1960

Lexington Park

St. Mary's

Maryland

St. Mary's

Burial Lexington Park

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10692 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10672

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Maddox Rural</u> c. LENGTH OF STAY IN 1b <u>Wicomico River</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>1350 K. St. S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Benjamin Dawkins</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>N.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-12</u> 9. AGE (In years last birthday) <u>47</u> yrs. IF UNDER 1 YEAR: Months <u>47</u> Days <u>47</u> Hours <u>47</u> Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elbert Dawkins</u>		14. MOTHER'S MAIDEN NAME <u>Florance Lyles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>WW II</u>	
17. INFORMANT <u>Address</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> DUE TO <u>850X</u> Conditions, if any, which gave rise to immediate cause (b) <u>850X</u> (a), stating the underlying cause last. (c) <u>850X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>SM. PLEASURE BOAT OVER TURNED</u>		20c. TIME OF INJURY Month, Day, Year <u>9-11-1960</u> Hour a.m. <u>4:00</u> p.m. <u>4:00</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>WICOMOCO RIV.</u>	
20f. (City or town) <u>MADDOX</u>		(County) <u>ST. MARY'S MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William D. Boyd M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>William D. Boyd M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9/14/60</u>	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or country) (State) <u>Arlington, Va.</u>
23. FUNERAL DIRECTOR <u>Latney Funeral Home 1822 - 11 th. ST. N.W.</u>		24a. REC'D BY REGISTRAR <u>DATE SEP 16 '60</u>	
ADDRESS <u>Washington, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Knapp</u>	

MEDICAL CERTIFICATION

10053 MEDICAL EXAMINER CERTIFICATE OF DEATH
DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS AND RECORDS
1973

10053

1

1

NAME: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

[illegible text]

William D. Boyd M.D.
Funeral Home 1222 - 11th St. N.W.
Washington, D.C.
Arlington, Virginia

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10685

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10673

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 30 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Raymond Middle Goldsborough Last 		4. DATE OF DEATH Month Sept. Day 30 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1896
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James T. Goldsborough		14. MOTHER'S MAIDEN NAME Ann Farrell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 	
17. INFORMANT Carrie M. Buckler		Address Mechanicsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 20 19 60 to Sept 25 19 60 that (I) (we) last saw the deceased alive on Sept 20 19 60 and that death occurred at 3 AM from the causes and on the date stated above.		22a. SIGNATURE Leon W. Berbue M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Leon W. Berbue MD		22d. ADDRESS Mechanicsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/3/60	
23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		23d. LOCATION (City, town, or county) (State) Morganza, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown, Maryland	
25a. REC'D BY REGISTRAR OCT 4 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

10003

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
IN SENATE
JANUARY 10, 1900

10003

REPORT OF THE
COMMISSIONERS OF THE LAND OFFICE
IN SENATE
JANUARY 10, 1900

REPORT OF THE
COMMISSIONERS OF THE LAND OFFICE
IN SENATE
JANUARY 10, 1900

1
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10686

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10674

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Alabama b. COUNTY Dallas	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 14 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS 40X-3	
3. NAME OF DECEASED (Type or print) First Edwin Middle Clarence Last Gullatte		4. DATE OF DEATH Month September Day 29 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1885
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edwin Gullatte		14. MOTHER'S MAIDEN NAME Elizabeth Dunn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Charles E. Cornthwaite		Address 155 Woodlawn Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular DUE TO (c) embolism of liver			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Town Creek Manor California, Md.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/19 19 60 , to 9/28 19 60 , that (I) <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Sept 28 19 60 , and that death occurred at 3 AM , from the causes and on the date stated above.			
22a. SIGNATURE J. Roy Guyther		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. Roy Guyther, M.D.		22d. ADDRESS Mechanicsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/1/60	
23c. NAME OF CEMETERY OR CREMATORY Antioch		23d. LOCATION (City, town, or county) (State) Opelika, Alabama	
24. FUNERAL DIRECTOR'S SIGNATURE Frederick's Funeral Home		25a. REC'D BY REGISTRAR DATE OCT 3 '60	
ADDRESS Opelika, Alabama		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

10082

CENTRAL OFFICE OF DEATH

10082

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CHESTERMAN

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VS A15 (4)
15M 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10693
CERTIFICATE OF DEATH

10675

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Saint Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River		c. LENGTH OF STAY IN 1b 1 hr 53 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Station Hospital, USNAS			d. STREET ADDRESS 10 Salamaua Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle Louise Last IHLE			4. DATE OF DEATH Month September Day 12 Year 1960		
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-60		9. AGE (In years lost birthday) yrs. 1 Months 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Raymond Henry IHLE		
14. MOTHER'S MAIDEN NAME Nancy Lou HILLMAN			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		
16. SOCIAL SECURITY NO. NA			17. INFORMANT 10 Salamaua Court Mother: Nancy Lou IHLE Lexington Park, Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 776X IMMEDIATE CAUSE (a) PREMATURE BIRTH, Neonatal Death with Immaturity DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 1 hr 53 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I attended the deceased from 9-12-1960 to 9-12-1960 , that I last saw the deceased alive on 12 September, 1960 , and that death occurred at 11:14 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 9/13/60 ACTUAL SIGNATURE D. S. Anderson M.D. _____ PHYSICIAN'S NAME (Type) D.G. ANDERSON LT MC USN Station Hospital USNAS PATUXENT RIVER, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/15/60		22c. NAME OF CEMETERY OR CREMATORY Jefferson Mem. Cem.	
22d. LOCATION (City, town, or county) _____ (State) _____		22e. REC'D BY REGISTRAR DATE SEP 16 '60			
22f. REGISTRAR'S SIGNATURE Clifford S. Kneib					
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.					

2051242XVO

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10694

CERTIFICATE OF DEATH

Reg. Dist. No.

10676

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tall Timbers		c. LENGTH OF STAY IN 1b X Tall Timbers	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) JOHN CLYDE JARBOE		4. DATE OF DEATH September 25 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1877
9. AGE (In years last birthday) 82 yrs.		10. BIRTHPLACE (State or foreign country) Maryland	11. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	
13. FATHER'S NAME John Oscar Jarboe		14. MOTHER'S MAIDEN NAME Katherine Cecil	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT J. Claude Jarboe - Leonardtown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1958 , to Sept 25, 1960 , that I last saw the deceased alive on Sept 24, 1960 , and that death occurred at 1 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE P.J. Bean		ADDRESS (Street, city or town, state) Great Mills, Md. DATE SIGNED 9/26/60	
PHYSICIAN'S NAME (Type) P.J. Bean, MD		Great Mills, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/60	
22c. NAME OF CEMETERY OR CREMATORY Holy Face Cemetery		22d. LOCATION (City, town, or county) (State) Great Mills, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE SEP 28 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

CERTIFICATE OF DEATH

10000



<p>NAME OF DECEASED JOHN DOE</p>		<p>DATE OF DEATH JAN 15 1900</p>	
<p>AGE 45</p>		<p>SEX M</p>	
<p>PLACE OF BIRTH BALTIMORE, MD</p>		<p>RESIDENCE 123 MAIN ST, BALTIMORE, MD</p>	
<p>CAUSE OF DEATH HEART DISEASE</p>		<p>PLACE OF DEATH HOME</p>	
<p>DATE OF BURIAL JAN 17 1900</p>		<p>PLACE OF BURIAL GREENWOOD CEMETERY</p>	
<p>SIGNATURE OF PHYSICIAN J. H. SMITH</p>		<p>SIGNATURE OF REGISTRAR W. B. JONES</p>	
<p>DATE OF SIGNATURE JAN 15 1900</p>		<p>DATE OF SIGNATURE JAN 15 1900</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10695

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10677

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maddox		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS 3404-13th St. N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wicomico River		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarabell Malish Johnson		4. DATE OF DEATH September 11 19 60	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1915
9. AGE (in years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician		10b. KIND OF BUSINESS OR INDUSTRY Hair Dressing	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rudolph Thomas		14. MOTHER'S MAIDEN NAME Nellie Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Nellie Thomas		Address 3404-13th St. N.W. Wash. DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Small out board motor boat sunk while pleasure cruising small out board motor boat sunk while pleasure cruising			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) small out board motor boat sunk while pleasure cruising	
20c. TIME OF INJURY Month, Day, Year 4 p. m. 9/11 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Wicomico river		20f. (City or town) (County) (State) Maddox, St. Marys, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Wm. D. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Wm. D. Boyd, MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/14/60	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cem. Suitland, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. Ernest Jarvis		24a. REC'D BY REGISTRAR SEP 16 '60	
24b. REGISTRAR'S SIGNATURE W. Ernest Jarvis		DATE SEP 16 '60	



RECEIVED
HEALTH DEPARTMENT
STATE OF NEW YORK
JAN 10 1910

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1007

1. Name of deceased: John J. Smith
2. Age: 45
3. Sex: Male
4. Color: White
5. Birth date: Jan. 1, 1865
6. Place of birth: New York City
7. Usual residence: 123 Main St., New York City
8. Cause of death: Heart disease
9. Date of death: Jan. 5, 1910
10. Time of death: 10:30 AM
11. Place of death: Home
12. Signature of medical examiner: [Signature]
13. Signature of attending physician: [Signature]
14. Signature of coroner: [Signature]
15. Signature of registrar: [Signature]

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FOR STATE
HEALTH DEPT.
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other action is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10696 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10678

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Patuxent River,				d. STREET ADDRESS Rt. # 1, Box. 300			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Fred Arnold Mitchel				4. DATE OF DEATH Month September Day 28 Year 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 4, 1913	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Station Emp.				10b. KIND OF BUSINESS OR INDUSTRY Gas (Fuel)			
11. BIRTHPLACE (State or foreign country) Wisconsin				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Bertran Mitchel				14. MOTHER'S MAIDEN NAME Matie Buck			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 2				16. SOCIAL SECURITY NO. 578-05-2864			
17. INFORMANT Mrs. Jessie Hoftizer - Hollywood, Md.				Address 			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 850X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH Immed.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Loss balance, fell from small boat, unable to swim:			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2 p.m. 9/28 19 60				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Patuxent River				20f. (City or town) (County) (State) Hollywood, St. Marys, Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE Wm. D. Boyd				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Wm. D. Boyd, MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 9/28/60							
Address (Street, city, town, or county) 							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/60		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Arlington, Va.	
23. FUNERAL DIRECTOR Simmons Bros.				ADDRESS 1661- Good Hope Rd. S.E. Washington, D.C.			
24a. REC'D BY REGISTRAR SEP 30 '60				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VETERINARY MEDICINE
WASHINGTON, D. C.



Office of the Director
Washington, D. C.
February 1, 1933
Dear Sir:
Reference is made to your letter of January 10, 1933, in which you request information regarding the procedure for the issuance of a license to a person desiring to practice veterinary medicine in the District of Columbia.
The following information is being furnished to you for your information:
1. A person desiring to practice veterinary medicine in the District of Columbia must first obtain a license from the Board of Veterinary Medicine.
2. The Board of Veterinary Medicine is composed of five members, three of whom are appointed by the Board of Health and two by the Board of Agriculture.
3. The Board of Veterinary Medicine meets on the first Monday of each month at 10:00 A. M. in the room designated for its use.
4. The Board of Veterinary Medicine will consider applications for licenses at its regular meetings.
5. The fee for a license is \$10.00.
6. The license is valid for one year.
7. The license may be renewed for another year by paying the fee again.
8. The license may be suspended or revoked by the Board of Veterinary Medicine.
9. The Board of Veterinary Medicine may also issue temporary licenses to persons who are unable to attend the regular meetings.
10. The Board of Veterinary Medicine may also issue licenses to persons who are unable to attend the regular meetings.
Very respectfully,
Director



Very respectfully,
Director
Bureau of Veterinary Medicine
Washington, D. C.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10679

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn,				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Jerry Norris				4. DATE OF DEATH Month Day Year Sept. 13, 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 16, 1899	
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Andrew Norris				14. MOTHER'S MAIDEN NAME Frances Gatton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO.		17. INFORMANT Rosie F. Norris Address Ridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 148 X IMMEDIATE CAUSE (a) Carcinoma of throat DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1958 to Sept 13, 1960 , that (I) (we) last saw the deceased alive on Sept 13, 1960 , and that death occurred at 5:50 AM from the causes and on the date stated above.							
22a. SIGNATURE P.J. Bean				22b. ADDRESS Great Mills, Maryland			
22c. PHYSICIAN'S NAME (Type) P.J. Bean M.D.				22d. ADDRESS Great Mills, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/16/60		23c. NAME OF CEMETERY OR CREMATORY St. Michael's		23d. LOCATION (City, town, or county) (State) Ridge, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				25a. REC'D BY REGISTRAR SEP 19 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

10034

CERTIFICATE OF DEATH

10034

St. Mary's Maryland St. Mary's

Leontine, 13 days and 12 days

St. Mary's Hospital

Thomas Jerry Morris Japt. 13-60

Male White Jan. 10, 1892 61

Maryland 1892

Andrew Morris Frances Carson

No. Rosie P. Morris 11th, No.

Ed. Dean 1892 Great Mills, Maryland

Dr. J. H. Dean 1892 St. Michael's 1892

W. Clarke 1892 Leontine, Maryland 1892

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 10688
 CERTIFICATE OF DEATH

10680

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn, Md				c. LENGTH OF STAY IN 1b 2 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle Francis Last Pilkerton				4. DATE OF DEATH Month 9 Day 1 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 18, 1893	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min.		11. IF UNDER 24 HRS. Months 67 Days 67 Hours 67 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY Bank		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Pikelerton				14. MOTHER'S MAIDEN NAME Mary Elizabeth Abell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Luke Goddard Address Drayden, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute dilatation of heart Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) coronary thrombosis (c) 2 hrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 hrs (b) 2 hrs (c) 2 hrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/1 19 60 , to 9/1 19 60 , that (I) (we) last saw the deceased alive on 9/1 19 60 and that death occurred at 8 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE Charles Greenwell				22b. DATE SIGNED SEP 7 '60		22c. PHYSICIAN'S NAME (Type) Dr. Charles Greenwell M.D.	
22d. ADDRESS Leonardtwn, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/5/60		23c. NAME OF CEMETERY OR CREMATORY St. George's		23d. LOCATION (City, town, or county) (State) Valley Lee Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				25a. REC'D BY REGISTRAR DATE SEP 7 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10697

CERTIFICATE OF DEATH

Reg. Dist. No.

10681

1. PLACE OF DEATH a. COUNTY St. Marys b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridge c. LENGTH OF STAY IN 1b X d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridge d. STREET ADDRESS Rural e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Inez First Lula Middle Ridgell Last		4. DATE OF DEATH September 15 Month 1960 Day Year				
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 2, 1880	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James S. Norris			14. MOTHER'S MAIDEN NAME F. Catherine Stone			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Emory P. Ridgell, Scotland, Md. Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus						INTERVAL BETWEEN ONSET AND DEATH 3 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 22 to Sept 14 , 19 60 , that I last saw the deceased alive on Sept 14 , 19 60 , and that death occurred at 7:50 AM , from the causes and on the date stated above.						
ACTUAL SIGNATURE P.J. Bean		PHYSICIAN'S NAME (Type) P.J. Bean, MD		ADDRESS (Street, city or town, state) Great Mills, Md.		DATE SIGNED 9/15/60
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/19/60		22c. NAME OF CEMETERY OR CREMATORY St. Michaels		22d. LOCATION (City, town, or county) (State) Ridge, Md.
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md. ADDRESS				24a. REC'D BY REGISTRAR DATE SEP 20 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Howard

CERTIFICATE OF DEATH

1900

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1855		Maryland		Baltimore		Heart Disease		Jan 15, 1900		Home		5:00 PM		J. Smith		A. Jones	
Occupation		Married		Single		Widowed		Divorced		Color		Race		Religion		Education		Previous Illness		Previous Injuries		Previous Operations	
Teacher		Yes		No		No		No		White		Caucasian		Protestant		High School		None		None		None	
Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Nurse		Signature of Undertaker		Signature of Burial Place		Signature of Cemetery		Signature of Funeral Home	
Jan 15, 1900		Home		5:00 PM		J. Smith		A. Jones		B. Brown		C. Green		D. White		E. Black		F. Gray		G. Blue		H. Red	

MEDICAL CERTIFICATION

VS. A15ME
5M 7/59



July 16, 1934 28 ix

Katy A.

James O. Somerville, Lonsdale, Md.

Printed 9/2/60 Second Year

Emmwood, Maryland

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10698

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film 6273 10-19-60 et

Reg. Dist. No.

10683

1. PLACE OF DEATH a. COUNTY St. Marys b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maddox c. LENGTH OF STAY IN 1b Washington d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wicomico River		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE District of Columbia b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington c. STREET ADDRESS 90 Que St.S.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Barbara Regina First Middle Last Swann		4. DATE OF DEATH Month Day Year September 11 19 60	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1926
9. AGE (In years last birthday) 33 34 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Dry cleaning	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Swann, Sr.		14. MOTHER'S MAIDEN NAME Carrie Tinker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 577-34-3101	
17. INFORMANT Robert Swann, Jr.		Address 67 Que St.S.W. Wash. DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH Immed.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) small out board boat sunk while pleasure cruising	
20c. TIME OF INJURY Month, Day, Year Hour 4 p.m. 9/11 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Wicomico river	20f. (City or town) (County) (State) Maddox, St. Marys, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Wm. D. Boyd EXAMINER'S NAME (Type) Wm. D. Boyd, MD		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9/12/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/15/60	22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cem.	22d. LOCATION (City, town, or county) (State) Suitland Md.
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines, Co.		24a. REC'D BY REGISTRAR 3015 -12th St. N.E.	24b. REGISTRAR'S SIGNATURE Washington, D.C.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 16 '60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10684

10699

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mechanicsville				c. LENGTH OF STAY IN 1b 9 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Loretta Middle Cecilia Last Wathen				4. DATE OF DEATH Month September Day 11 , Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1928	
9. AGE (In years last birthday) 32 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME William Douglas Morgan				14. MOTHER'S MAIDEN NAME Cora Elizabeth Tippet			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. noje		17. INFORMANT W. Douglas Wathen Address Mechanicsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 200.0 IMMEDIATE CAUSE (a) Reticulum cell sarcoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 mo.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 to Sept 10 1960 , that (I) (we) last saw the deceased alive on 9 PM 9/14/60 , and that death occurred at 3 PM from the causes and on the date stated above.							
22a. SIGNATURE <i>Leon W. Berube</i>				22b. DATE SIGNED 9/14/60		22c. PHYSICIAN'S NAME (Type) Leon W. Berube	
22d. ADDRESS Mechanicsville, Maryland				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/14/60		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's		23d. LOCATION (City, town, or county) (State) Morganza, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				24b. ADDRESS Leonardtwn, Md.		25a. REC'D BY REGISTRAR DATE SEP 13 '60	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							

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